Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
FONDREN ORTHOPEDIC GROUP LLP

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-15-0719-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
OCTOBER 23, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We received the explanation of benefits showing where code 76499 was denied. You are requesting a valid CPT. The comparable is 73590 since there is no other code for more views for the lower extremity. Therefore we are asking that you review this claim once again but using this code listed above."

Amount in Dispute: $44.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed unlisted radiology code 76499 for a tibia-fibula fracture rather than a specific existing code for an x-ray of the lower extremity. Texas Mutual belives this is incorrect coding and denied payment as such."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 20, 2014	CPT Code 76499 Unlisted Diagnostic Radiographic Procedure	$44.24	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, *33 Texas Register 364*, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment
   - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration.

- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 714-Accurate coding is essential for reimbursement. CPT/HCPCS billed incorrectly. Corrections must be submitted w/I 95 days from DOS.
- 724-No additional payment after a reconsideration of services.
- 725-Approved non network provider for Texas Star Network Claimant per rule 1305.153(C).

Issues

Does the documentation support billed service? Is the requestor entitled to reimbursement for code 76499?

Findings

According to the submitted explanation of benefits, the respondent denied reimbursement for CPT code 76499 based upon reason code "714."

28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

28 Texas Administrative Code §134.203(b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

Per National Correct Coding Initiative Policy Manual for Medicare Services, Revision Date January 1, 2014, Chapter 1 "The *CPT Manual* includes codes to identify services or procedures not described by other HCPCS/CPT codes. These unlisted procedure codes are generally identified as XXX99 or XXXX9 codes and are located at the end of each section or subsection of the manual. If a physician provides a service that is not accurately described by other HCPCS/CPT codes, the service should be reported utilizing an unlisted procedure code. A physician should not report a CPT code for a specific procedure if it does not accurately describe the service performed. It is inappropriate to report the best fit HCPCS/CPT code unless it accurately describes the service performed, and all components of the HCPCS/CPT code were performed. Since unlisted procedure codes may be reported for a very diverse group of services, the NCCI generally does not include edits with these codes."

The requestor states in the position summary that "The comparable is 73590 since there is no other code for more views for the lower extremity."

CPT code 73590 is defined as "Radiologic examination; tibia and fibula, 2 views."

A review of the June 20, 2014 progress report states "AP, lateral and oblique x-rays look good." The requestor also submitted a copy of a Swissray Study History Search Form that indicates "RT DISTAL Tibia-Fibia 4V." The X-ray report was not submitted to support billed service. As a result, no reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		05/14/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.